

EXTREMITY SUBLUXATION CORRELATIONS

PART II: TMJ

Abstract

Temporomandibular joint (TMJ) dysfunction may display as symptoms almost anywhere in the body. This aberrant TMJ motion may at times be related to extraspinal subluxations.

Introduction

According to Penfield and Rasmussen, 35 – 40% of all motor and sensory nerves of the body are related to the TMJ. Thus TMJ dysfunction has far reaching effects on overall body function. A few of these would include but are not limited to cranial-sacral primary respiratory motion, leg length discrepancies, pelvic categories, gait imbalances, upper cervical subluxations-fixations, P.L.U.S. patterns, etc. Goodheart, Leaf, Gelb, and many others have been researching and demonstrating the relationship between the TMJ and remote body function for over twenty-five years via Applied Kinesiology. TMJ dysfunction may be caused by a variety of different things, including extremity subluxations.

Discussion

There are basically two different methods of diagnosing TMJ dysfunction via manual muscle testing; without T.L. to the TMJ and with T.L. to the TMJ. Starting with a strong indicator muscle the subject is asked to clench his/her teeth together. If this creates a weakening of the strong indicator muscle, traditionally some type of occlusal and/or tooth problem exists. This author has not correlated an extremity subluxation for this pattern. Next the subject is asked to open wide and again the indicator muscle is tested. If positive, (indicator muscle weakens), then this demonstrates a need to fascial flush one or more of the TMJ closing muscles (masseter, temporalis, internal pterygoid). However, also check the extremities for an extraspinal subluxation including the glenohumeral joint, navicular, and/or cuboid. The patient at this point is usually asked to open/close the mouth slowly and then rapidly without letting the teeth touch each other to check for an aerobic/anaerobic involvement. If positive then iron/pantothenic acid is given to negate the positive test. Extraspinally check for a patellar subluxation.

The subject is now requested to T.L. the TMJ without movement. This should create no weakening of the strong indicator muscle. If positive, then this usually indicates disc pathology or a small intestine involvement. Extremity subluxation involvements may include a posterior tibia, talus, cuboid, and/or a superior third cuneiform. The patient is then requested to clench his/her teeth together while therapy localizing the TMJ. If positive, we then have the patient T.L. to the three closing muscles while biting down. If positive the spindle cells are turned down manually to the muscle belly. Extraspinal subluxations related to this may be a slipped bicipital tendon, and/or femur head involvement. The subject is then asked to open the mouth while continuing to therapy localize to the TMJ. If positive, one side is therapy localized at a time and the appropriate inferior division of the external pterygoid spindle cells are manually turned down. From

an extraspinal viewpoint, check for a medial olecranon or a talus subluxation. Once again, continuing to TL the TMJ, the subject is asked to lateralize the jaw to the right and then to the left. If positive, to the left, for example, then the TMJ is therapy localized one side at a time. If positive therapy localization to the left TMJ while lateralizing the jaw to the left, then the left posterior temporalis spindle cells are turned down. If positive therapy localization to the right TMJ while lateralizing to the left, then the right internal pterygoid spindle cells are turned down. Extremity subluxation correlations include a femur head, posterior tibia, and/or a posterior calcaneus. The patient is then requested to protrude the jaw and if positive then each side is therapy localized to determine involvement. The inferior division of the external pterygoid spindle cells are then turned down to the involved side(s). Extremity subluxations to be investigated would be the posterior tibia, posterior calcaneus, anterior distal tibia, cuboid, and/or a superior third cuneiform. Finally, the patient is requested to retrude the jaw. If positive, therapy localize to the masseters and then to the posterior temporalis muscles while retruding the jaw. The appropriate spindle cells are then manually turned down. Extraspinal involvement would include the glenohumeral joint, posterior radial head, fibular head, superior second cuneiform, and/or superior third cuneiform.

In summary the following patterns have been observed.

TMJ Dysfunction	Extremity Subluxation
W/Out T.L. to TMJ	
Closing	N/A
Opening	Glenohumeral Joint Navicular Cuboid
* Open/Close w/out Touching teeth (Movement is Slow/Rapid)	Patella *
W/ T.L. to TMJ	
Neutral	Tibia Talus Cuboid 3 rd cuneiform
Close	Bicipital tendon Femur head
Open	Olecranon Talus

Lateralization

Femur head
Tibia
Calcaneus

Protrusion

Tibia
Calcaneus
Tibia (distal)
Cuboid
3rd cuneiform

Retrusion

Glenohumeral
Radial head
Fibular head
2nd cuneiform
3rd cuneiform

Conclusion

The extremity subluxations presented here have an effect on TMJ dysfunction as correlated. When the extraspinal subluxations are the cause of TMJ dysfunction, this has a profound and wide-ranging effect on total body function and harmony. Correction of the extremity subluxation is of paramount importance at certain times in treating a patient from a holistic perspective. To find the cause is the highest good (Hippocrates).

References

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